AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

May 23, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Guidance

5/18/12 IRS/Treasury issued the Health Insurance Premium Tax Credit final regulations (§1402, §1411, §1412). The final regulations amend the Income Tax Regulations to implement the health insurance premium tax credit provisions of the ACA. The final regulations provide guidance to individuals and families who enroll in Qualified Health Plans (QHPs) through Affordable Insurance Exchanges (exchanges) and use the premium tax credit to help purchase that health insurance, and to exchanges that make qualified health plans available to individuals and employers. The premium tax credits help defray insurance costs and make it easier for middle-income people to purchase affordable health insurance starting in 2014 when health plans will be available through Exchanges.

To be eligible to receive the premium tax credit, individuals and families must have incomes between 100%- 400 % FPL and be enrolled in a QHP through an exchange. The individual must also be ineligible for employer or other government sponsored insurance. The amount of the premium tax credit is tied to the amount of the premium. The expected contribution is a specified percentage of the taxpayer's household income. The percentage increases as income increases, from 2% of income for families at 100% FPL to 9.5% of income for families at 400% FPL. In the final rule, the IRS said that the agency would issue future regulations about determining the affordability of family (in addition to "self-only") employer-sponsored coverage and eligibility advanced premium tax credits.

According to the Treasury, the tax credit is advanceable, so it can lower consumers' monthly premium payments and it is refundable, so even moderate-income families who may have little federal income tax liability (but who may pay a higher share of their income towards payroll taxes and other taxes) can receive the full benefit of the credit. The tax credit is paid in advance directly to an insurer on a monthly basis and the taxpayer must claim it on their

annual income tax return. However, final eligibility for the credit cannot be determined until the taxpayer files their annual return which has household income information for the year. A "reconciliation" then occurs between the tax credit already received by the consumer and the amount that the individual is actually entitled. If over the course of the year household income changes and is greater or less than what was projected, the final tax credit may be greater or less than the amount already paid. If the taxpayer turns out to have been eligible for more than had been paid, the taxpayer gets a refund. Although the liability is limited for the taxpayer, if the government has paid more than the taxpayer was found to be entitled to the taxpayer must pay the money or portion of the tax credit back to the government.

Comments on certain items are due August 21, 2012.

Read the Treasury Department Fact Sheet at:
http://www.treasury.gov/press-center/press-releases/Pages/tg1587.aspx

Read the regulation (published in the Federal Register on May 23, 2012)
at: http://www.gpo.gov:80/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf

5/17/12 HHS published a correction to the final "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" rule. The document corrects technical and typographic errors in the Reinsurance, Risk Corridors and Risk Adjustment final rule (also known as the Health Insurance Premium Stabilization final rule) that was published in the Federal Register on March 23, 2012. The final rule implements standards under §1341, §1342, §1343 of the ACA for states related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment. The ACA set up three risk-mitigation programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch in 2014. These programs include transitional reinsurance (§1341), temporary risk corridors programs (§1342), and a permanent risk adjustment program (§1343).

Read the correction to the final rule at: http://www.gpo.gov:80/fdsys/pkg/FR-2012-05-17/pdf/2012-11994.pdf

Read the final rule at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

5/16/12 CCIIO issued a "Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." The guidance lays out how states will demonstrate to HHS how their Affordable Insurance Exchange will operate as authorized under §1311(b) of the ACA to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014.

An Exchange both facilitates the purchase of Qualified Health Plans (QHP) by qualified individuals and provides for the establishment of a Small Business Health Options Program (SHOP). Exchanges will provide competitive marketplaces for individuals and small employers to directly compare and purchase private health insurance options. In designing and operating Exchanges to most appropriately meet the needs of their citizens and their marketplace, the ACA provides states with flexibility. States can choose to either operate as a state-based Exchange or the HHS Secretary will establish and operate a Federally-facilitated Exchange. In a Federally-facilitated Exchange, the state may pursue a State Partnership Exchange, where a state may administer and operate Exchange activities associated with plan management and/or consumer assistance.

Regulations implementing the ACA require HHS to approve or conditionally approve state-based Exchanges no later than January 1, 2013, for operation in 2014. In addition, ACA §1321(c)

directs the Secretary to make a determination regarding whether the state will operate reinsurance and/or risk adjustment programs or will use federal government services for these activities. To receive HHS approval or conditional approval for a state-based Exchange or a State Partnership Exchange, as well as reinsurance and risk adjustment programs, a state must complete and submit an Exchange Blueprint that documents how its Exchange meets or will meet all legal and operational requirements associated with the model it chooses to pursue. According to HHS, as part of its Exchange Blueprint, a state must also demonstrate operational readiness to execute Exchange activities.

View the state Exchange Blueprint, visit:
http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf

Read the final Exchange rule at:
http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

5/16/12 CCIIO issued "General Guidance on Federally Facilitated Exchanges." The guidance outlines HHS' approach to implementing a Federally-facilitated Exchange (FFE) under ACA §1321 in any state where a state-based Exchange is not operating. The ACA allows each state the opportunity to establish an Affordable Insurance Exchange to help individuals and small employers purchase affordable health insurance coverage. Coverage through the Exchange will begin in every state on January 1, 2014, with enrollment beginning October 1, 2013. Recognizing that not all states may elect to establish a state-based Exchange by this statutory deadline, the ACA directs the HHS Secretary to establish and operate an FFE in any state that does not elect to do so, or will not have an operable Exchange for the 2014 coverage year, as determined by January 1, 2013.

In addition to describing HHS's high-level operational approach, the document also describes how the agency will consult with a variety of stakeholders to implement an FFE, where necessary, how states can partner with HHS to implement selected functions in an FFE, and key policies organized by Exchange function.

Read the guidance on the FFEs at:
http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

Prior guidance can be viewed at www.healthcare.gov

News

5/18/2012 HHS announced that, as of March 31, 2012, the Pre-Existing Condition Insurance Plan (PCIP) under ACA §1101 is providing insurance to over 61,000 people with high-risk pre-existing conditions nationwide. The PCIP program is a temporary federal program designed to cover uninsured Americans with pre-existing conditions until 2014. In 2014, individuals will be able to purchase health insurance through the Exchange where they cannot be denied coverage because of a pre-existing condition. The new numbers show that there are 14 Massachusetts residents who are enrolled in this program. Massachusetts and Vermont are guarantee-issue states where existing commercial plans already offer guaranteed coverage at premiums comparable to PCIP so the need for such a program may not be as high as in other states. In May 2011 CMS announced a policy change to the PCIP in states with a federally-administered PCIP program, such as Massachusetts. The change stated that United States citizens and nationals who have been without health insurance for at least six months can qualify for coverage if they can provide a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability, or illness. Applicants

do not need to provide a denial letter from an insurance company. This may have provided an additional opportunity for individuals with pre-existing conditions in the state who might have to wait up to eleven months to enroll in other plans in the state due to eligibility or open enrollment restrictions under Massachusetts law. The last enrollment update, which shows enrollment through February 29, 2012, showed 11 enrollees in the state.

For more information, visit:
http://www.healthcare.gov/news/factsheets/2012/05/pcip05182012a.html

5/18/12 CMS announced that two new Consumer Oriented and Operated Plan (CO-OP) repayable loans will be awarded to non-profit entities to help them establish private non-profit, consumer-governed health insurance companies to offer qualified health plans in the health insurance exchanges. Established under §1322 of the ACA, the goal of CO-OP program is to create a new CO-OP in every state in order to expand the number of exchange health plans with a focus on integrated care and plan accountability.

New non-profits receiving loans include: The Michigan Consumer's Healthcare CO-OP received a $71,534,300 loan to provide coverage statewide. Michigan Consumer's Healthcare CO-OP is sponsored by a coalition of 15 county health plans, which are private, non-profit corporations that provide a limited health coverage benefit to low-income individuals in Michigan. The Nevada Hospitality Health CO-OP received a $65,925,396 loan to provide health insurance coverage statewide. Hospitality Health CO-OP is sponsored by the Culinary Health Fund, its national parent Unite HERE Health, and the Health Services Coalition. Hospitality Health CO-OP will operate for all individuals in the Exchanges and the individual and small group markets.

Starting in 2014, CO-OPs will be able to offer plans both inside and outside of health insurance exchanges and will operate in 12 states, including: Michigan, Nevada, Maine, South Carolina, Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, New Jersey, and New York. CMS awarded the first round of CO-OP loans on February 21, 2012. To date a total of $982,472,104 has been awarded. CMS will continue to review applications on a quarterly schedule through December 31, 2012 and announce additional awardees on a rolling basis. According to CMS, CO-OP loans are only made to private, nonprofit entities that demonstrate a high probability of financial viability.

For more information, including a list of the first CO-OP loans awarded, visit:
http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html

5/16/12 Health Affairs published a study called "Individual Insurance Benefits To Be Available Under Health Reform Would Have Cut Out-Of-Pocket Spending In 2001-08." According to the study, if the ACA had been in place between 2001 and 2008 adults covered under an individual health insurance policy would have saved approximately $280 a year in out-of-pocket (OOP) spending for medical care and prescription drugs. In fact, average OOP spending by people ages 55 to 64 and by low-income adults ages 26 to 64 likely would have decreased even more - by $589 and $535, respectively.

The study states that although most U.S. adults get their coverage from an employer, about 11 million people buy individual policies. The individual market is generally more expensive than employer-based coverage, and individual policies typically carry higher out-of-pocket costs, such as co-pays or deductibles. However, according to the study, individual health insurance is likely to be more comprehensive and similar to coverage people get through employers because of the ACA.

Several provisions under the ACA make individual policies more generous and may lead to OOP savings for consumers. Health plans sold through Affordable Insurance Exchanges (§1311) will

be required to cover certain essential health benefits (§1302), such as prescription drugs, and some preventive services will have to be made available without a co-pay (§2713). The ACA also reduces cost-sharing for people below 400% FPL who buy plans in the Exchanges (§1402) and removes lifetime and unreasonable annual limits to coverage (§2711).

Read the Health Affairs study at:
http://content.healthaffairs.org/content/early/2012/05/11/hlthaff.2011.1206.full

Read the HHS fact sheet at:
http://www.healthcare.gov/news/factsheets/2012/05/consumer-spending05162012a.html

5/16/12 HHS announced awards of more than $181 million in Affordable Insurance Exchange grants to 6 states to help them create exchanges under ACA §1311. Establishment Grant funding provides resources to states to set up exchanges and implement the ACA. States receiving Level One Exchange Establishment grants awards, which provide one year of funding to states that have begun the process of building their Exchange, are: Illinois, Nevada, Oregon, South Dakota and Tennessee. HHS also announced that Washington was awarded a Level Two Establishment grant, the second state to receive such an award, which is provided to states that are further along in building their Exchange and offers funding over multiple years.

This announcement brings the number of states receiving Exchange Establishment awards to a total of 34 states and the District of Columbia, bringing the cumulative award total to more than $856 million in Establishment grants to date. Previously, 49 states and the District of Columbia received Exchange Planning grants (totaling more than $54 million) and seven states received Early Innovator grants (totaling more than $249 million). Massachusetts received a $1 million planning grant in September 2010 and is the leading partner in a consortium of the six New England states that received a $35.6 million Early Innovator grant in February 2011. In February 2012 Massachusetts received an $11.6 million Level One Exchange Establishment Grant.

HHS will continue to award exchange establishment grants through 2014. For a detailed state-by-state breakdown of grant awards including each state's plan for how to use its Exchange funding, visit: http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html

Upcoming Events

Insurance Market Reform Work Group Open Stakeholder Meetings
The Insurance Market Reform Work Group, co-chaired by the Health Connector and the Division of Insurance, is hosting a series of open meetings to solicit feedback on a range of topics under its purview. The meeting schedule and proposed topics are highlighted below. If any interested persons are unable to attend the meetings in person, they can participate in the session by calling the number below. We highly encourage people to attend in person as the acoustics in the Hearing Room can be difficult.
Dialing Instructions:
Dial 1-877-820-7831
Pass Code 9630386# (please make sure to press # after the number).

ACA-related dental services and products
May 25, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston, Hearing Room E, DOI Offices

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.